

## Section 6: Prior Approval

Prior approval (PA) may be required for some services, products, or procedures to verify medical necessity. All requests for PA must be submitted in accordance with DMA's clinical coverage policies and published procedures (but see discussion under "Early and Periodic Diagnostic, Screening and Treatment" in this section of the billing guide). PA is for medical approval only. PA must be obtained **before** rendering a service, product, or procedure that requires PA. Obtaining PA does **not** guarantee payment or ensure recipient eligibility on the date of service. A recipient must be eligible for Medicaid coverage on the date the procedure is performed or the service rendered.

The recipient must meet all medical necessity PA criteria. **However**, the federal Social Security Act (the Act) found at 1905(r) requires the state Medicaid agency to provide to Medicaid recipients under 21 years of age "necessary health care, diagnostic services, treatment, and other measures described in section 1905(a) of the Act to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the State plan." Additionally, if the recipient is under 21 years of age, service limitations on scope, amount, duration, and/or frequency and other specific criteria described in clinical coverage policies may be exceeded or may not apply provided that documentation shows the requested service is medically necessary to correct or ameliorate a defect, physical or mental illness, or a condition identified by a licensed clinician. This special provision for recipients under 21 years of age is known as Early and Periodic Screening Diagnostic and Testing (EPSDT). EPSDT criteria are specified below, and **all criteria must be met to approve coverage under EPSDT**. A list of EPSDT services is located in this section.

1. EPSDT services must be coverable services within the scope of those listed in the federal law at 42 U.S.C. § 1396d(a) [1905(a) of the Social Security Act]. For example, "rehabilitative services" are a covered EPSDT service, even if the particular rehabilitative service requested is not listed in DMA clinical policies or service definitions.
2. The service must be medically necessary to correct or ameliorate a defect, physical or mental illness, or a condition [health problem] diagnosed by the recipient's physician, therapist, or other licensed practitioner. By requiring coverage of services needed to correct or ameliorate a defect, physical or mental illness, or a condition [health problem], EPSDT requires payment of services that are medically necessary to sustain or support rather than cure or eliminate health problems to the extent that the service is needed to correct or ameliorate a defect, physical or mental illness, or condition [health problem].
3. The requested service must be determined to be medical in nature.
4. The service must be safe.
5. The service must be effective.
6. The service must be generally recognized as an accepted method of medical practice or treatment.
7. The service must not be experimental/investigational.

Additionally, services can only be covered if they are provided by a N.C. Medicaid-enrolled provider for the specific service. For example, only a N.C. Medicaid-enrolled durable medical equipment (DME) provider may provide DME to a Medicaid recipient. This may include an out-of-state provider who is willing to enroll if an in-state provider is not available.

If a service, product, or procedure requires PA, requests made on behalf of recipients under 21 years of age are **NOT** exempt from the PA requirement. Further information about EPSDT is available in **Section 2** of this billing guide, the PA table and list of EPSDT services found in this section, and DMA's EPSDT Policy Instructions, on the Web at <http://www.ncdhhs.gov/dma/EPSDTprovider.htm>

To determine if a procedure requires PA, refer to DMA's clinical coverage policies, listed on the Web at <http://www.ncdhhs.gov/dma/mp/index.htm>. Providers may also call the automated voice response (AVR) system at 1-800-723-4337. Refer to **Appendix A** for information on using the AVR system.

## **Important Points about Prior Approval**

- 1. In accordance with 10A NCAC 22J.0106 (d), providers cannot bill recipients when the provider failed to follow program regulations.**
2. Retroactive PA is considered when a recipient, who does not have Medicaid coverage at the time of the procedure, is later approved for Medicaid with a retroactive eligibility date. Exceptions **may apply** as indicated below.

- a. Recipients enrolled in a Community Alternatives Program (CAP)
  - b. Hospice Election Reporting PA. Refer to Medicaid's Clinical Coverage Policy #3D, *Hospice Services*, on DMA's Web site for further information. The Web address is <http://www.ncdhhs.gov/dma/mp/mpindex.htm>
  - c. If a recipient has been placed in a nursing facility, the PA date for nursing facility level of care may be retroactive to 30 days prior to the date the FL2 is approved by the fiscal agent or up to 90 days with the FL2 and supporting records.
3. Before admitting recipients for procedures requiring PA, hospital office personnel must determine that the physician has completed all of the necessary PA forms. The primary surgeon has the responsibility of obtaining PA from the EDS Prior Approval Unit or DMA staff, as appropriate.
  4. Behavioral health referrals for outpatient services for children may be obtained from the local management entity, Medicaid-enrolled psychiatrist, or the primary care physician. This is not an authorization. It is a referral process that must take place **before** the provider sees the child. Authorization must be obtained from ValueOptions.  
For psychiatric services, the admissions are usually emergent, and the hospital has 48 hours to obtain PA from ValueOptions. All other mental health services require PA from ValueOptions as well.
  5. Unless a service is exempt from the Carolina ACCESS/Community Care of North Carolina referral and authorization requirement, providers must obtain a referral authorization from the Carolina ACCESS enrollee's primary care provider in addition to requesting PA for any service or procedure that requires it. See "Referrals and Authorizations" in **Section 4** of this billing guide for additional information.
  6. Some requests for PA are submitted to DMA or DMA's authorizing agents [such as The Carolinas Center for Medical Excellence (CCME), ValueOptions, ACS Pharmacy, etc.], but most requests are submitted to Medicaid's fiscal agent, EDS. A few PA requests may be approved verbally by the fiscal agent and followed up with a written request. However, when a request for PA may be made verbally to the fiscal agent and it can be approved, the request is approved **tentatively** effective the date of the call, contingent upon receipt of the written request within 10 days of the call to the fiscal agent. If the written request is not received in the required time, the request will be denied. Following the required timeframes, a new PA request may be submitted at any time. Please see the PA table at the end of this section to determine which services may receive **tentative** verbal PA.
  7. **Except in emergency situations, all services provided to Medicaid recipients by out-of-state providers must be approved prior to rendering the service. Emergency coverage ends as soon as the recipient is stable. Medicaid will not pay for out-of-state services once a recipient is stable.**
  8. The AVR system provides information regarding a recipient's last routine eye exam or refraction only. It is in the provider's best interest to obtain an authorization/confirmation number on the day of service, prior to rendering the service.
  9. DMA staff and vendors will make every effort possible to make a decision about a PA request within 15 business days. There may be times when a request for PA does not contain sufficient information for Medicaid to determine whether the request should be approved or denied. In that event, Medicaid notifies the recipient and provider in writing that the request lacks the necessary documentation to review the request and specifies the deadline date for submission of additional information by the provider as well as where and how to submit the

information. The provider must submit additional documentation as specified by Medicaid staff or contractors within 15 business days of the date of the notice for additional information.

Medicaid recognizes that there may be situations when 15 business days are not sufficient time for a response. If a provider is unable to submit the additional information within 15 business days from the date of the request, s/he must contact Medicaid or its contractors to request a time extension. It is not necessary for the provider to explain the reason for the time extension. Medicaid allows the provider no more than an additional 15 business days from the date of the contact to submit the requested information. If there is no response from the provider or if the provider does not submit the additional information within the 15-business-day time period, the provider and recipient are notified in writing that the request was denied for insufficient information.

10. The table that appears at the end of this section summarizes information about some services that require PA. For complete information, refer to individual clinical coverage policies for specific instructions regarding PA. Policies are linked from DMA's Web site at <http://www.ncdhhs.gov/dma/mp/mpindex.htm>.

## Early and Periodic Screening, Diagnostic and Treatment

For a more detailed explanation of EPSDT, see DMA's EPSDT Policy Instructions at: <http://www.ncdhhs.gov/dma/EPSDTprovider.htm> and **Section 2** of this *Guide*.

1. If the service, product, or procedure requires PA, the fact that the recipient is under 21 years of age does **NOT** eliminate the requirement for PA.
2. If the recipient under 21 years of age does not meet the coverage criteria set forth in the clinical coverage policy, the provider must request and obtain PA from the appropriate authorizing agent **BEFORE** the service is rendered, whether or not PA is required.
3. If the service, product, or procedure is **NOT** one for which PA is required but the recipient under 21 years of age needs to exceed established limits, the provider must request and obtain PA from the appropriate authorizing agent (such as EDS, ValueOptions, CCME, DMA, etc.) **BEFORE** the limit is exceeded. Please refer to the PA table at the end of this section to determine the appropriate authorizing agent.
4. PA requests for non-covered state Medicaid plan services are requests for services, products, or procedures not included in the North Carolina State Medicaid Plan **but coverable** (medically necessary to correct or ameliorate a defect, physical or mental illness, or a condition identified through a screening examination) under federal Medicaid law, 1905(r) of the Social Security Act. To review the listing of federal EPSDT services, products, or procedures coverable under federal Medicaid law, see the listing of EPSDT services at the end of this section.
5. Requests to cover non-covered state Medicaid plan services must be submitted to DMA prior to rendering the service.
6. EPSDT PA authorization is time limited to the first of the following occurrences:
  - a. the recipient reaches 21 years of age **OR**
  - b. the time limit specified by the PA is exhausted **OR**
  - c. 365 days elapses from the date of the PA.
7. If the recipient is **over 21 years of age and the service has not been provided**, although PA was granted before his or her 21st birthday, follow DMA's published procedures and submit a new request for PA if PA is required. See the specific clinical coverage policy

and this *Guide* for complete details regarding provision of and payment for services rendered. Clinical coverage policies can be found at the Web site

<http://www.ncdhhs.gov/dma/mp/mpindex.htm>

8. If the recipient is **under 21 years of age and the authorization has expired** and if the service, product, or procedure is still desired and is medically necessary to correct or ameliorate a defect, physical or mental illness, or a condition identified by screening, submit a new request for PA. See the specific clinical coverage policy and this *Guide* for complete details regarding provision of and payment for services rendered.
9. The provider has up to 365 days from the date the service is rendered to submit the claim for payment. See specific clinical coverage policy and this *Guide* for complete details regarding provision of and payment for services rendered.
10. The service must be rendered in accordance with the PA granted, including service approved, number of units approved, and time period of approval, if relevant.
11. If PA is required, the provider must request and obtain PA *before* rendering the service, product, or procedure in order to seek Medicaid payment. Remember, obtaining PA does not guarantee payment or ensure recipient eligibility on the date of service. The recipient must meet clinical policy coverage criteria, where applicable, and must be Medicaid eligible on the date the service, product, or procedure is provided.
12. The form may be found at the end of this section or on DMA's Web site at <http://www.ncdhhs.gov/dma/forms.html> (look under **Provider Forms, then Prior Approval**). Recipients may also obtain a request form by calling the CARE-LINE Information and Referral Services, Monday through Friday, except state holidays, at the numbers specified below.

#### **Research Triangle Area (Raleigh–Durham–Chapel Hill vicinity)**

English/Spanish	919-855-4400
TTY number for the deaf or hearing impaired	919-733-4851

#### **Outside Triangle Area**

English/Spanish	800-662-7030
TTY number for the deaf or hearing impaired	877-452-2514

## **General Requests for Prior Approval**

The Request for Prior Approval (form 372-118) is used by several service types to assist in the review of medical necessity for the requested services. PA requests must be submitted in writing using this form. **To obtain this form, contact EDS Provider Services at 1-800-688-6696.** Once a PA has been issued, it must be used within the time limit set forth by the PA **OR** within 365 days, whichever time period is less. The following services use this form:

- Some surgeries
- Out-of-state elective services
- Services to Medicaid for Pregnant Women recipients
- Hearing aid services
- Therapeutic leave over 15 consecutive days
- Eye exam or refraction services beyond established limitations

- Out-of-state and state-to-state ambulance service  
**Note:** A completed and signed State-to-State Ambulance Transportation Addendum Form (372-118A) must accompany the PA request.
- Transplants (See “Procedures for Approval and Reimbursement of Transplants” in this section)

If Medicaid’s fiscal agent (EDS) is the authorizing agent, mail the completed form to

EDS—Prior Approval Unit  
P.O. Box 31188  
Raleigh NC 27622

Requests approved by other authorizing agents must be submitted to that agent. See the PA table at the end of this section to determine the authorizing agent. It is also important to remember that if services are to continue and the PA is time limited, PA must be requested again before the limits are met to avoid an interruption in service and payment.

## Denial of Prior Approval

A decision on a request for PA will be acted on with reasonable promptness (usually within 15 business days of receipt of the request). The provider will be notified in writing of a PA, denial, or any reduction or termination of services using the prescribed state form, and the recipient will be notified in writing of any denial, reduction, or termination of services. When a decision is made to deny, reduce, or terminate services for a recipient under 21 years of age, the decision will specify the reasons that the EPSDT standard is not met. The notice will be issued in accordance with DMA’s recipient notices procedures. Such a denial can be appealed in the same manner as any Medicaid service denial, reduction, or termination.

## Requests for Specific Types of Prior Approval

### Community Alternatives Program Participation

The purpose of CAP is to offer community-based care to certain targeted populations as an alternative to institutionalization, as long as the care required can be delivered safely and is cost effective. Admission to and continuation of services in any CAP requires physician approval and is overseen by a CAP case manager. Admission to the program begins with the following:

1. Referral to the program
2. Completion of an FL2 signed and dated by the recipient’s physician and approved at the nursing facility level of care [for CAP/Children (CAP/C) and CAP/Disabled Adults (CAP/DA)] or completion of an MR2 approved at the Intermediate Care Facility for Persons with Mental Retardation (ICF-MR) level for CAP/Mentally Retarded-Developmentally Disabled (CAP/MR-DD)

**Note:** Case managers are encouraged to submit the FL2 electronically.

3. Thorough assessment of the recipient to determine appropriateness for CAP
4. Evaluation of the assessment and level of care document to determine appropriateness for CAP

The CAP programs, lead agencies, and Web sites are identified below.

Program	Lead Agency	Web Site
CAP/C	DMA–Home Care Initiatives Unit	<a href="http://www.ncdhhs.gov/dma/cc/capc.htm">http://www.ncdhhs.gov/dma/cc/capc.htm</a>
CAP/DA	Appointed County Agency	Lead agency listing: <a href="http://www.ncdhhs.gov/dma/commaltprog.htm">http://www.ncdhhs.gov/dma/commaltprog.htm</a>
CAP/MR-DD	Division of Mental Health, Developmental Disabilities and Substance Abuse Services (MHDDSAS)	<a href="http://www.ncdhhs.gov/mhddsas/">http://www.ncdhhs.gov/mhddsas/</a>

Further information about CAP is available in specific clinical coverage policies, program manuals, and the Web sites specified above.

### Out-of-State or State-to-State Ambulance Service

PA is required for ambulance service by ground or air from North Carolina to another state, from one state to another, or from another state back to North Carolina. PA for ambulance service is separate from PA for a medical procedure or treatment provided out of state. Requests for PA must be submitted on the general Request for Prior Approval form (372-118) and the State-to-State Ambulance Transportation Addendum form (372-118A).

### Long-Term-Care Services

The FL2 Long-Term Care Services form (372-124 paper; FL2e electronic) is used by several programs for approval of long-term-care nursing services. If a telephone review results in approval of the FL2, the approval is **tentative (not final)**, pending submission of a completed form within 10 days of the telephone call to the fiscal agent. The FL2 must be submitted as the hard copy original or electronically through Provider Link. Should the submitted FL2/FL2e fail to validate that the recipient requires nursing facility level of care at the level specified by the requestor and in accordance with DMA's recipient notices procedure, the request may be denied or reduced, or additional information may be requested. Additionally, if the FL2/FL2e is not submitted within the required timeframe, the FL2/FL2e will be denied. The following services use this form:

- Out-of-state long-term care (nursing facility)
- Long-term-care nursing
- Ventilator-dependent care
- CAP/C, CAP/Choice, CAP/DA for level of care determinations

Providers are encouraged to submit the FL2 electronically. All electronic requests for long-term-care nursing services must be submitted through Provider Link using the FL2e form.

### Services Provided to the Mentally Retarded

*This section is under construction and will be posted at a later date.*

### Optical Services—Routine Eye Exams with Refractions

Routine eye exams with refractions do not require PA. However, it is in the best interest of the provider to call the AVR system to verify the last date of service and receive an authorization/confirmation number for the patient record. If a second routine eye exam with refraction is requested within the time limitation period, PA is required. A general Request for Prior Approval (form 372-118) documenting medical necessity must be submitted and approved prior to rendering the service.



Refer to **Appendix A** for information about using the AVR system to obtain PA for eye exams with refractions.

## Optical Services—Visual Aids

All visual aids require PA, and requests must be submitted on a Request for Prior Approval for Visual Aids (form 372-017 or 372-017A). To obtain this form, contact EDS Provider Services at 1-800-688-6696. In some cases, this form must be accompanied by required documentation. Refer to the *Optical Services Manual* on DMA's Web site at <http://www.ncdhhs.gov/dma/optical.htm> for information on services and limitations.

## Hearing Aids, Frequency Modulation Systems, and Accessories

All hearing aids, frequency modulation (FM) systems, repairs, replacement parts, and accessories require PA. Requests must be submitted using the general Request for Prior Approval (form 372-118) along with a letter from the physician or otologist (including otolaryngologist or otorhinolaryngologist) certifying the need for beginning the hearing aid selection process, a copy of a hearing evaluation (including audiogram), the results of the hearing aid selection and evaluation tests, and a copy of the hearing aid manufacturer's warranty information.

- In block 10 on the PA, record the manufacturer, model, and cost of requested aid.
- Also in block 10, document the type of aid being requested (Analog Programmable, Digital Programmable, or FM System).
- In block 12, document the reason(s) the recipient requires the requested system.

Refer to Clinical Coverage Policy #7, *Hearing Aid Services*, on DMA's Web site at <http://www.ncdhhs.gov/dma/mp/mpindex.htm> for information on services and limitations.

## Dental Services

Requests for PA for dental services are submitted using the 2006 ADA form. Only PA requests for services that are indicated as requiring PA should be submitted to the EDS Prior Approval Unit. Refer to the Dental Program Policy Manual (#4A, *Dental Services*, and #4B, *Orthodontic Services*) on DMA's Web site at <http://www.ncdhhs.gov/dma/mp/mpindex.htm> for information on dental services and limitations.

The two-part form must be used when requesting PA. The original is returned to the provider and serves as the PA/claim copy. The second page is retained by EDS. Until the original is returned, providers should keep a copy for their office records, noting the date the PA request was mailed.

## Durable Medical Equipment and Orthotic and Prosthetic Devices

Some DME items and orthotic and prosthetic devices (O&P) require PA. In those cases, the Certificate of Medical Necessity/Prior Approval (CMN/PA) form must be submitted to EDS for review. The CMN/PA is reviewed to ensure that the item is medically necessary to maintain or improve a recipient's medical, physical, or functional level and that it is suitable and appropriate for use in the recipient's private residence or adult care home.



PA requests for DME and O&P that do not appear on DMA's lists of covered equipment but are **medically** necessary under EPSDT should be submitted to DMA at

Assistant Director  
Clinical Policy and Programs  
Division of Medical Assistance  
2501 Mail Service Center  
Raleigh NC 27699-2501  
FAX: (919) 715-7679

PA is valid for the time period approved on the CMN/PA form. If a physician decides that an item is needed for a longer period of time, a new CMN/PA form must be submitted.

Refer to clinical coverage policies #5A, *Durable Medical Equipment*, and #5B, *Orthotic and Prosthetic Devices*, on DMA's Web site at <http://www.ncdhhs.gov/dma/mp/mpindex.htm> for additional information.

### **Enhanced Care (Adult Care Home)**

The ACH staff makes a referral request for enhanced care on behalf of the recipient to the local county DSS by sending a copy of the latest FL2, the 3050R, and other referral documents, as necessary. The local DSS assigns a case manager, conducts an independent assessment, and approves the recipient for enhanced care services, if appropriate. The case manager calls this approval in to the fiscal agent, receives a service review number, and sends the resident and the provider a decision notice.

### **Adult Care Home Special Care Unit for Persons with Alzheimer's and Related Disorders**

Effective October 1, 2006, Medicaid implemented a special care rate for ACH providers operating special care units for persons with Alzheimer's and related disorders (SCU-A). The provider must receive PA before admitting a new resident to a SCU-A. The provider must complete the SCU-A Prior Approval Form and submit it, along with all supporting documents, to

Adult Care Homes Unit  
Facility and Community Care Section  
Division of Medical Assistance  
2501 Mail Service Center  
Raleigh NC 27699-2501

The PA request form and instructions can be found on DMA's Web site at <http://www.ncdhhs.gov/dma/forms.html>, under Adult Care Homes.

### **Hospice Participation**

Hospice providers must notify EDS when a Medicaid recipient elects the hospice benefit as well as when hospice benefits are revoked, a recipient is discharged from hospice, or a recipient transfers from one hospice to another. This includes Medicare/Medicaid hospice patients in nursing facilities for whom Medicaid is paying room and board. Hospice participation information may also be obtained using the AVR system for dates of service beginning May 1, 2000.

Refer to **Appendix A** for information about using the AVR system.

### **Utilization Review for Psychiatric Services**

N.C. Medicaid contracts with ValueOptions to provide utilization review of acute inpatient/substance abuse hospital care, psychiatric residential treatment facilities (PRTFs), Levels I through IV residential treatment facilities, therapeutic foster care outpatient psychiatric services, enhanced benefits, and

Criterion #5. ValueOptions reviews and approves the requests based on medical necessity according to established criteria.

For recipients **over 21 years of age** and after the eighth visit, providers must obtain authorization from ValueOptions for continued outpatient mental health services. Recipients **under 21 years of age** are allowed 26 unmanaged visits before PA is required.

Copies of the PA form can be obtained by calling ValueOptions at 1-888-510-1150.

Refer to the May 2006 Special Bulletin, *Enhanced Benefit Mental Health/Substance Abuse Services*, on DMA's Web site at <http://www.ncdhhs.gov/dma/bulletin.htm>, for additional information.

## Outpatient Specialized Therapies

N.C. Medicaid contracts with CCME to perform the PA process for outpatient specialized therapies. PA is required for treatment services. There are six unmanaged visits per discipline, per provider type or 6-month exemption from PA once in a lifetime. It is always safer to obtain PA since you may not be aware of previous services.

If treatment is to continue after the six unmanaged visits or 6-month exemption, the PA request should be made at approximately the second or third unmanaged visit to allow sufficient time for processing. Prior Authorization Requests for Outpatient Specialized Therapy Services may be faxed to CCME at 1-800-228-1437 or submitted electronically for treatment to be continued. If appropriate, CCME will authorize services for a specific number of units through a specific length of time. Units should be requested based on the CPT code billed. A copy of the form and electronic submission instructions are available on CCME's Web site at <https://www2.mrnc.org/priorauth/pages/Home.aspx>. Once the limits have been reached, PA must be requested again for continued treatment.

Refer to Clinical Coverage Policy #10A, *Outpatient Specialized Therapies*, on DMA's Web site at <http://www.ncdhhs.gov/dma/mp/mpindex.htm> for additional information.

## Certain Prescription Drugs

N.C. Medicaid contracts with ACS State Healthcare to manage the PA process for the drugs listed below. Additional drugs requiring PA may occasionally be added. Providers will be notified of these changes via the general Medicaid bulletin (<http://www.ncdhhs.gov/dma/bulletin.htm>) and/or through the Pharmacy Newsletter (<http://www.ncdhhs.gov/dma/pharmnews.htm>).

- Botox, Myobloc
- Celebrex
- Growth hormones
- OxyContin
- Procrit, Epogen, Aranesp
- Proton pump inhibitors
- Provigil
- Sedative hypnotics

The prescriber contacts the ACS Clinical Call Center (in Henderson, North Carolina) directly by telephone, fax, e-mail, or mail. Pharmacists may dispense a 72-hour emergency supply without PA.

Copies of the prescription PA forms may be obtained by contacting ACS State Healthcare (telephone 1-866-246-8505 or online at <http://www.ncmedicaidpbm.com>).

\*PA may be overridden if criteria are met (refer to May 2007 Pharmacy Newsletter).

## Transplants

When a hospital transplant team determines that a recipient requires a transplant (solid organ or stem cell), all of the supporting documentation justifying the medical necessity for the procedure must be sent to DMA for pre-approval **regardless of where Medicaid is in the payment priority**.

Retroactive PA will not be authorized for any recipient who does not have Medicaid coverage at the time of the procedure, except when a recipient is later approved for Medicaid with a retroactive eligibility date.

After the documentation is reviewed, the physician and the facility will receive a notification of approval or denial from DMA. In order for N.C. Medicaid to review a request for transplant coverage for a dually eligible recipient, providers must submit a copy of the insurance denial or payment from the primary payer with the claim, the request for coverage of the transplant service, and the complete clinical evaluation packet. These must be received within 180 days of the transplant procedure. **Requests without complete clinical evaluation packets will not be considered.** Upon receipt of these documents, DMA will conduct a dually eligible post review and make a determination, using clinical policy guidelines, as to whether Medicaid coverage is available. Clinical packets **must** be complete, according to the requirements below, in order to be reviewed.

Fax clinical packets to the transplant nurse consultant at 919-715-0051. The packet must include the documentation specified below as well as the clinical documentation indicated in the specific transplant **clinical coverage** policies, available on DMA's Web site at <http://www.ncdhhs.gov/dma/mp/mpindex.htm>.

### Solid Organ Transplant Packets

- Letter from physician requesting transplant and summarizing clinical history
- All recent lab results, including HIV, RPR, hepatitis panel, PT, INR, infectious disease serology including CMV, and EBV

**See below for complete lab requirements. No lab results can be more than 3 months old.**

- All recent diagnostic and procedure results (**not** more than 3 months old)
- Complete psychological and social evaluation with documentation of post-transplant care needs of patient and/or family, as indicated, that accurately depicts support, compliance, etc.
- Recipients with a psychiatric history are required to have a psychiatric evaluation
- Recipients with a history of or active substance abuse are required to show documentation of substance abuse program completion and 6 months of negative sequential random drug and alcohol screens

**Note:** To satisfy the requirement for sequential testing as designated by policy, DMA must receive a series of test (alcohol and drug) results spanning at least 6 months, with no fewer than a 3 weeks and no more than 6 weeks between tests during the given time period. A complete clinical packet must include at least one documented test performed within 1 month of the date of the request in order to be considered for PA.

- Other organ-specific policy criteria (<http://www.ncdhhs.gov/dma/mp/mpindex.htm>; see the **clinical coverage** policies in group 11B)

Additional clinical or other documentation may be requested.

### Stem Cell Transplant Packets

- Letter from physician requesting transplant and summarizing clinical history
- Previous chemotherapy regimes and dates
- All recent lab results, including HIV, RPR, hepatitis panel, PT, INR, infectious disease serology including CMV, and EBV

**See below for complete lab requirements. No lab results can be more than 3 months old.**

- All diagnostic and procedure results, including bone marrow aspiration (**not** more than 3 months old)
- Complete psychological and social evaluation with documentation of post-transplant care needs of patient and/or family, as indicated, that accurately depicts support, compliance, etc.
- Recipients with a psychiatric history are required to have a psychiatric evaluation
- Recipients with a history of or active substance abuse are required to show documentation of substance abuse program completion and 6 months of negative sequential random drug and alcohol screens as specified above.
- Other disease-specific policy criteria (<http://www.ncdhhs.gov/dma/mp/mpindex.htm>; see the **clinical coverage** policies in group 11A)

Additional clinical or other documentation may be requested.

**Lab results** required in a complete packet include CBC, liver enzymes, complete electrolytes, PT, INR, HIV, Hep, RPR, EBV, CMV, Varicella, rubella, T protein, Ca, BUN, HSV I/II amylase, lipase, phosp, mag, AFP (depending on the diagnosis), glucose and AIC, cholesterol and trig (depending on history), blood type, MELD/PELD score, LD, uric acid, T. bili, GGT, and recipient height and weight. Other lab tests may be requested.

## Quick Reference Table—Prior Approval for Certain Medicaid Services

More detailed information about most entries in this table is printed in the front of this section.

Service	Verbal Authorization	Written Authorization
CAP/C, CAP/Choice, CAP/DA Approval for level of care only—does not constitute approval to participate in CAP.	Call EDS (1-800-688-6696 or 919-851-8888) to receive tentative verbal approval. Information called in must be from a completed Long-Term Care Services form (FL2) (372-124).	The completed FL2 (hard copy original FL2 or electronic FL2e through Provider Link) must be received by EDS within 10 days of the telephone call. Case managers are encouraged to use the FL2e whenever possible.
Dental	No verbal authorization allowed.	Complete a 2006 ADA claim form and submit to EDS .
Durable Medical Equipment	No verbal authorization allowed.	Complete a CMN/PA (form 372-131 (8/02)) and submit to EDS.
EPSDT: State Medicaid Plan Services for Recipients under 21 Years of Age	No verbal authorization allowed.	Submit completed applicable program PA form(s) to the appropriate authorizing agent along with documentation that shows the request will correct or ameliorate a defect, physical or mental illness, or a condition identified by a licensed clinician before providing the service. The reviewer will request additional information if needed.
EPSDT: Non-covered State Medicaid Plan Services for Recipients Under 21 Years of Age	No verbal authorization allowed. Important note: This procedure is only for requesting services under EPSDT that are <i>never</i> otherwise covered under the N.C. Medicaid State Plan. To request covered services for recipients under 21 years of age in excess of numerical limits or other specific criteria in clinical coverage policies, see EPSDT for State Medicaid Plan Services immediately above.	Submit completed Non-Covered State Medicaid Plan Services Request form <i>before</i> providing the service, product, or procedure. The form must be completed by the recipient's physician or other licensed clinician. The request must show that <b>ALL EPSDT criteria are met</b> . The reviewer will determine if the request is a coverable service. If additional information is required, the reviewer will request it.
Eye Examinations with Refractions	PA not required. Call the AVR system (800-723-4337; alternate 800-688-6696) for the last date of service and an authorization/confirmation number.	Complete a general Request for Prior Approval (form 372-118) for medically necessary exceptions to the time period limitations and submit to EDS.
Hearing Aids and Accessories	No verbal authorization.	Complete a general Request for Prior Approval (form 372-118) and submit to EDS.

Service	Verbal Authorization	Written Authorization
Hospice	Call EDS (800-688-6696 or 919-851-8888) to report hospice benefit election.	Hospice election must be reported within 7 calendar days of the start of hospice services. PA for hospice reporting cannot be granted retroactively beyond the 7-day timeframe.
Intermediate Care Facility for Persons with Mental Retardation	<i>Section under construction and will be posted at a later date.</i>	<i>Section under construction and will be posted at a later date.</i>
Long-Term Care (FL2)	Call EDS (800-688-6696 or 919-851-8888) to receive tentative verbal approval.	The completed FL2 (hard copy original FL2 or electronic FL2e through Provider Link) must be received by EDS within 10 days of the telephone call. Providers are encouraged to use FL2e.
Medicaid for Pregnant Women	No verbal authorization.	Complete a general Request for Prior Approval (form 372-118) and/or appropriate referral form for the following services: Visual aids and eye exams Podiatric services Dental services DME Home health Hospice Personal Care Services (PCS) Private duty nursing (PDN) Home infusion therapy Chiropractic services
Orthotic and Prosthetic Devices	Only for emergency repairs to orthotics or prosthetics. Call EDS (800-688-6696 or 919-851-8888).	Complete a CMN/PA (form 372-131 (8/02)) and submit to EDS.
Out-of-State Non-Emergency Services	No verbal authorization; call EDS (800-688-6696 or 919-851-8888) for information and instructions for obtaining out-of-state approval.	Complete a general Request for Prior Approval (form 372-118). Add medical records and a letter from the attending physician requesting out-of-state services and stating why the services cannot be provided in North Carolina. Fax requests to 919-233-6834.
Out-of-State and State-to-State Ambulance Service	No verbal authorization; call EDS (800-688-6696 or 919-851-8888) to receive information and instructions for obtaining out-of-state and state-to-state ambulance services approval.	Complete a general Request for Prior Approval (form 372-118) and an Out-of-State and State-to-State Ambulance Transportation Addendum form (372-118A). Follow EDS instructions for when and how to submit the request.

Service	Verbal Authorization	Written Authorization
Outpatient Specialized Therapies	No verbal authorization.	Fax (800-228-1437) or electronically submit ( <a href="https://www2.mrnc.org/priorauth/pages/Home.aspx">https://www2.mrnc.org/priorauth/pages/Home.aspx</a> ) a Prior Approval for Outpatient Specialized Therapies form to CCME.
PCS–Plus	No verbal authorization.	Complete a PCS–Plus Request Form (DMA 3000-A; online at <a href="http://www.ncdhhs.gov/dma/forms.html">http://www.ncdhhs.gov/dma/forms.html</a> ) and fax to DMA (919-715-2628).
Prescription Drugs	Call ACS State Healthcare (866-246-8505) for information and instructions.	Fax completed Pharmacy PA forms to ACS State Healthcare (866-246-8507).
Private Duty Nursing (PDN)	Call DMA (919-855-4380) for PDN consultation. Upon review of faxed information, the PDN consultant will provide verbal authorization as indicated.	Complete and fax a PDN Referral form and a Physician’s Request form (both online at <a href="http://www.ncdhhs.gov/dma/forms.html">http://www.ncdhhs.gov/dma/forms.html</a> ) documenting medical necessity to DMA (919-715-9025).
Psychiatric Services, Inpatient (PRTF, Residential Child Care, Criterion #5, Out-of-State and Residential Services)	ValueOptions (888-510-1150)	
Psychiatric Services, Outpatient, Enhanced Benefit Services, Developmental Disability, and CAP/MR-DD	ValueOptions (888-510-1150)	
Surgery	No verbal authorization; call EDS (800-723-4337) to verify if a surgery requires PA.	Complete a general Request for Prior Approval (form 372-118) and submit to EDS. Include documentation supporting medical necessity as specified in individual clinical coverage policies.
Therapeutic Leave in excess of 15 consecutive days (for residents in nursing facilities and ICF-MRs) <b>Note:</b> for residents in PRTFs and Residential Care facilities, therapeutic leave is limited to 15 days per quarter.	Not applicable	Authorization is embedded in the residential authorization, as therapeutic leave is a part of the plan of care and must be documented as such.
Tocolytic Infusion Therapy	No verbal authorization.	Complete a Tocolytic Prior Approval Request Form (online at <a href="http://www.ncdhhs.gov/dma/forms.html">http://www.ncdhhs.gov/dma/forms.html</a> ) and fax to CCME (919-380-9457). Include applicable supporting documents.



<b>Service</b>	<b>Verbal Authorization</b>	<b>Written Authorization</b>
Transplants	No verbal authorization.	Fax completed packets/requests to the DMA transplant nurse consultant (919-715-0051).
Visual Aids	No verbal authorization.	Complete Prior Approval Request for Visual Aids form (372-017 or 372-017A) and submit to EDS. Include documentation of medical necessity for exceptions.

**Listing of EPSDT Services Found at 42 U.S.C. § 1396d(a) [1905(a) of the Social Security Act]**

- Inpatient hospital services (other than services in an institution for mental disease)
- Outpatient hospital services
- Rural health clinic services (including home visits for homebound individuals)
- Federally-qualified health center services
- Other laboratory and X-ray services (in an office or similar facility)
- EPSDT (*Note: EPSDT offers periodic screening services for recipients under age 21 and Medicaid covered services necessary to correct or ameliorate a diagnosed physical or mental condition*)
- Family planning services and supplies
- Physician services (in office, recipient's home, hospital, nursing facility, or elsewhere)
- Medical and surgical services furnished by a dentist
- Home health care services (nursing services; home health aides; medical supplies, equipment, and appliances suitable for use in the home; physical therapy, occupation therapy, speech pathology, audiology services provided by a home health agency or by a facility licensed by the State to provide medical rehabilitation services)
- Private duty nursing services
- Clinic services (including services outside of clinic for eligible homeless individuals)
- Dental services
- Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders
- Prescribed drugs
- Dentures
- Prosthetic devices
- Eyeglasses
- Services in an intermediate care facility for the mentally retarded
- Medical care, or any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law, specified by the Secretary (also includes transportation by a provider to whom a direct vendor payment can appropriately be made)
- Other diagnostic, screening, preventive, and rehabilitative services, including any medical or remedial services (provided in a facility, a home, or other setting) recommended by a physician or other licensed practitioner of the healing arts within the scope of their practice under State law, for the maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level
- Inpatient psychiatric hospital services for individuals under age 21
- Services furnished by a midwife, which the nurse-midwife is legally authorized to perform under state law, without regard to whether the nurse-midwife is under the supervision of, or associated with, a physician or other health care provider throughout the maternity cycle
- Hospice care
- Case management services
- TB-related services
- Respiratory care services

- Services furnished by a certified pediatric nurse practitioner or certified family nurse practitioner, which the practitioner is legally authorized to perform under state law
- Personal care services (in a home or other location) furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for the mentally retarded, or institution for mental disease
- Primary care case management services

Definitions of the above federal Medicaid services can be found in the Code of Federal Regulations 42 CFR 440.1-440.170 at [http://www.access.gpo.gov/nara/cfr/waisidx\\_06/42cfr440\\_06.html](http://www.access.gpo.gov/nara/cfr/waisidx_06/42cfr440_06.html).



**North Carolina**  
 Department of Health and Human Services  
**Division of Medical Assistance**  
 2501 Mail Service Center - Raleigh, N.C. 27699-2501

Michael F. Easley, Governor  
 Dempsey Benton, Secretary

William W. Lawrence, Jr., M.D., Acting Director

**FORM AVAILABLE ON DMA WEB SITE AT <http://www.ncdhhs.gov/dma/forms.html>**

**NON-COVERED STATE MEDICAID PLAN SERVICES REQUEST FORM  
 FOR RECIPIENTS *UNDER* 21 YEARS OF AGE**

**RECIPIENT INFORMATION:** *Must be completed by physician, licensed clinician, or provider.*

**NAME:** \_\_\_\_\_  
**DATE OF BIRTH:** \_\_\_\_/\_\_\_\_/\_\_\_\_ (mm/dd/yyyy)      **MEDICAID NUMBER:** \_\_\_\_\_  
**ADDRESS:** \_\_\_\_\_  
 \_\_\_\_\_

**MEDICAL NECESSITY:** *ALL REQUESTED INFORMATION, including CPT and HCPCS codes, if applicable, as well as provider information must be completed. Please submit medical records that support medical necessity.*

<b>REQUESTOR NAME:</b> _____ <b>MEDICAID PROVIDER #:</b> _____ <b>ADDRESS:</b> _____ _____ <b>TELEPHONE #:</b> (____) _____ <b>FAX #:</b> _____	<b>PROVIDER NAME:</b> _____ <b>MEDICAID PROVIDER #:</b> _____ <b>ADDRESS:</b> _____ _____ <b>TELEPHONE #:</b> (____) _____ <b>FAX #:</b> _____
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**IN WHAT CAPACITY HAVE YOU TREATED THE RECIPIENT** (incl. length of time you have cared for recipient and nature of the care): \_\_\_\_\_  
 \_\_\_\_\_

**PAST HEALTH HISTORY** (incl. chronic illness): \_\_\_\_\_  
 \_\_\_\_\_

**RECENT DIAGNOSIS(ES) RELATED TO THIS REQUEST** (incl. onset, course of the disease, and recipient's current status): \_\_\_\_\_  
 \_\_\_\_\_

**TREATMENT RELATED TO DIAGNOSIS(ES) ABOVE** (incl. previous and current treatment regimens, duration, treatment goals, and recipient response to treatment(s)): \_\_\_\_\_  
 \_\_\_\_\_

NAME:

MID #:

DOB:

NAME OF REQUESTED PROCEDURE, PRODUCT, OR SERVICE (if *applicable, please include CPT AND HCPCS codes*). PROVIDE DESCRIPTION RE HOW REQUEST WILL CORRECT OR AMELIORATE THE RECIPIENT'S DEFECT, PHYSICAL OR MENTAL ILLNESS OR CONDITION [THE PROBLEM]. THIS DESCRIPTION ***MUST*** INCLUDE A DETAILED DISCUSSION ABOUT HOW THE SERVICE, PRODUCT, OR PROCEDURE WILL IMPROVE OR MAINTAIN THE RECIPIENT'S HEALTH IN THE BEST CONDITION POSSIBLE, COMPENSATE FOR A HEALTH PROBLEM, PREVENT IT FROM WORSENING, OR PREVENT THE DEVELOPMENT OF ADDITIONAL HEALTH PROBLEMS.

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IS THIS REQUEST FOR EXPERIMENTAL/INVESTIGATIONAL TREATMENT:

☐ YES ☐ NO IF YES, PROVIDE NAME AND PROTOCOL # \_\_\_\_\_

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IS THE REQUESTED PRODUCT, SERVICE, OR PROCEDURE CONSIDERED TO BE SAFE:

☐ YES ☐ NO IF NO, PLEASE EXPLAIN. \_\_\_\_\_

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IS THE REQUESTED PRODUCT, SERVICE OR PROCEDURE EFFECTIVE: ☐ YES ☐ NO  
IF NO, PLEASE EXPLAIN. \_\_\_\_\_

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ARE THERE ALTERNATIVE PRODUCTS, SERVICES, OR PROCEDURES THAT WOULD BE MORE COST EFFECTIVE BUT SIMILARLY EFFICACIOUS TO THE SERVICE REQUESTED: ☐ YES ☐ NO IF YES, SPECIFY WHAT ALTERNATIVES ARE APPROPRIATE FOR THE RECIPIENT AND PROVIDE EVIDENCE BASE WITH THIS REQUEST, IF AVAILABLE. \_\_\_\_\_

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WHAT IS THE EXPECTED DURATION OF TREATMENT:

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<b>NAME:</b>	<b>MID #:</b>	<b>DOB:</b>
<b>OTHER ADDITIONAL INFORMATION:</b> _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____		
_____ <b>REQUESTOR'S SIGNATURE AND CREDENTIALS</b>		_____ <b>DATE</b>
<b><i>INCLUDE EVIDENCE-BASED LITERATURE TO SUPPORT THIS REQUEST IF AVAILABLE.</i></b>		
<b>MAIL OR FAX COMPLETED FORM TO:</b>		
<i>Assistant Director Clinical Policy and Programs Division of Medical Assistance 2501 Mail Service Center Raleigh, NC 27699-2501 FAX: 919-715-7679</i>		
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